Aberfoyle and Buchlyvie Medical Centre

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FK8 3UX

Drs Morrison and Cox

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www.aberfoyle-buchlyviesurgeries.co.uk

NEW PATIENT HEALTH QUESTIONNAIRE

Please complete this questionnaire as fully as possible

Personal Details

Title _____

First Name _____

Surname _____

Date of Birth _____

Address _____

_____

_____

Telephone Number _____

Mobile Number _____

Email _____

Next of Kin (name and telephone number) _____
Relationship to you

_____

What is your occupation? _____

Ethnicity

I would describe my ethnicity as (please circle below)

White Scottish	Indian	African	Other
White British	Pakistani	Black or Black Scottish	White Irish
Bangladeshi	Other Asian	Caribbean	Other Ethnic Group
Other White	Chinese	Any mixed background	

Medical History

Please tell us about current conditions, past conditions and any operations including date

Medication

Please list any medication that you are currently taking

Name | Dose

Allergies

Do you have any allergies? Yes/No

If so, please list

Family History

Please list any illnesses that run in your family

Heart Disease	Yes / No	Relationship to you:
Diabetes	Yes / No	Relationship to you:
Stroke/TIA	Yes / No	Relationship to you:
Asthma	Yes / No	Relationship to you:
High Blood Pressure	Yes / No	Relationship to you:
Cancer	Yes/No	Relationship to you:
If yes, type		

Lifestyle

Do you take regular exercise Yes/No
If yes, how often and type

Do you smoke Yes/No
If yes how many per day?

Do you drink alcohol Yes/No
If yes, how many units per week?

What is your height? What is your weight?

Carers and Being Cared For

Do you care for someone? Yes/No
Do you have a carer? Yes/No
If yes, what is your relationship with the person being cared for/your carer

Is the person registered with this practice? Yes/No
Name of person cared for

For Women Only

When was your last cervical smear?
Which method of contraceptive, if any do you use?
How many pregnancies have you had
Type of delivery